APPLICATION FOR AUTHORIZATION AS AN APPROVED CONTINUING EDUCATION PROVIDER FOR PREHOSPITAL EMERGENCY MEDICAL SERVICES PERSONNEL

Program Director:

Provider Mailing Address:	Provider Location (if other than mailing address):					
Program Clinical Director:	Primary Contact Person:					
Phone Number:	Fax Number:					
Dravidania a/any (Chash One)						
Provider is a/an: (Check One) () Local EMS Agency	() EMT Training Program					
() Other Governmental Agency	() Other School/College/University					
() Prehospital Service Provider Agency() Hospital	() Other CE Provider() CA Statewide Public Safety Agency					
() Individual	() CE Provider Headquartered in Another State					
Estimated Number of Prehospital CE Courses t	o be Provided:					
Division 9, Chapter 11, EMS Continuing Educa all regulations described. I agree to comply wit certify that all information on this application, to	gulations (California Code of Regulations, Title 22, tion) and that the applicant agency will comply with h all audit and review provisions. Furthermore, I the best of my knowledge, is true and correct. I egulations may result in revocation of CE approval					
Signature CE Program Director	<u>Date</u>					
Submit application and fee to the appropriate CE Provider approving authority. Please Attach:						

Resume(s) of CE Program Director and Program Clinical Director, which demonstrate individual(s) experience and qualifications in prehospital care/education.

as described in the CE regulations.

Application Fee -- \$200 (except statewide public safety agencies)

For local EMS agency or State EMS Authority use only

2.

CE Provider Name:

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	Application Received Date	Reviewed By	Approval Date	Expiration Date	Provider Number	Comments-Place on Reverse Side	Fee Paid/Date